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Hope or hype in the treatment of schizophrenia – what's the role of the physician?

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Psychiatrists' attitudes towards outcomes from schizophrenia are lacking in *'hope'*; this is not only demoralizing for patients and their families but limits the extent to which psychiatrists utilize the interventions that hold promise for improving outcomes – using clozapine, long-acting injectable antipsychotic medications (LAIs) and psychosocial interventions. This seems a controversial statement that most psychiatrists would disagree with, however the experience of mental health users is that professionals often have a negative perspective of schizophrenia that they suggest directly affects them, making them less hopeful[1]. This lack of hope is evidenced by the failure to offer these treatment options to patients, thus, denying patients the potential benefits of these treatments and indeed contributes to a self-fulfilling prophecy of poor outcomes. Here we examine the basis of this biased view of outcomes in schizophrenia, that directly influence psychiatrists' own 'hope' towards the prognosis and impacts on their decisions concerning pharmacological and psychological therapy. We also discuss the impact of 'hype' related to new discoveries in the field, which in the long term may have a deleterious effect on treatment.

What is hope? In the medical literature the term '*hope'* is frequently cited as a fundamental element for a successful treatment [1, 2]. Hope has many definitions including a positive perspective of the future; the expectation of achieving an objective; an effective coping strategy; an inner power that enables one to overcome obstacles (for review see [3]). As originally theorized by Snyder et al.[3], the 'hope theory' refers to an individual's positive perspective that make them invest energy and planning toward goal attainment. Hope is often confused with optimism; optimism or 'hype' is related to the individual's general expectancy for good rather than bad outcomes in their life. The hope theory intends to assess one's capacity to select appropriate routes and overcome barriers to goals rather than just one's confidence in a positive outcome. This can best be exemplified by the following analogy – an optimistic person would expect no rain and therefore leave home without an umbrella, while the hopeful person would expect no rain but take an umbrella to cope with any unexpected rain. How can one

evidence the importance of hope? One could examine data from diseases where it is possible to have biological measures of outcomes – an example would be diabetes mellitus. Van Allen et al.[2] prospectively examined the associations between patients' hope and optimism with health outcomes in a sample of young people with Type 1 diabetes mellitus; they found that *hope* improved glycaemic control while *optimism* did not help – they suggest interventions that could be used to improve patients' hope.

Although hope is a key element for recovery [1], how many psychiatrists have a truly positive perspective of outcomes in schizophrenia? Schizophrenia has traditionally been viewed as a neurodegenerative chronic condition with a very pessimistic outlook. The tautological approach in which the diagnosis of schizophrenia is questioned when there is complete return to premorbid functioning still prevails. Perhaps it is not surprising that psychiatrists display higher scores of negative stereotypes of schizophrenia and perceived prejudice than the general population [4].

So why is it that clinicians still have a negative perspective of schizophrenia? According to Cohen and Cohen [5], psychiatrists suffer from 'the clinician's illusion' – since the patient population who seek specialized treatment are chronic, more severe and have more comorbidities, which *per se* presents the worst outcome of the disease, however this group is not representative of the range of schizophrenia. Clearly, sustaining a positive perspective about treatment effectiveness in this scenario is very challenging; given this negative bias it is difficult for clinicians to remain hopeful and focus energy and planning towards the best treatment strategies available for each patient.

What opportunities for change have arisen recently? There have been significant advances in our understanding of schizophrenia; there is a wealth of clinical and neurobiological data demonstrating that schizophrenia is a neurodevelopmental disorder with heterogeneous phenotypes and a markedly diverse range of outcomes [4]. Similarly, recent large cohort studies have shown that the evolution of the disease is more favourable than previously thought [4].

What are the best treatment strategies for the people with schizophrenia? Although, the hype of neurobiological research has not yet provided a reliable set of predictors of the disease trajectory, there is robust evidence showing that antipsychotic medications and psychosocial interventions are fundamental elements in improving outcomes in schizophrenia [6]. In order to discuss the implication for clinical attitudes, we focus on three established aspects of the treatment of schizophrenia that have a fundamental role in lowering rates of relapse and hospitalization; a) patients whose recovery is limited by poor adherence offered a trial of LAI; b) patients who respond poorly to first and second line antipsychotic (treatment-resistant (TR)) encouraged to have a trial of clozapine, and c) patients with persistent symptoms and/or social interactions offered adjunct psychosocial treatments [7, 8, 9, 10]. All of these interventions are recommended in the treatment guidelines for schizophrenia, including both those of the American Psychiatric Association and the UK National Institute for Health and Care Excellence (NICE).

Surprisingly, despite the clear advantages offered by LAI, clozapine and psychosocial interventions, their use remains limited [7, 8, 9, 10]. Although non-adherence reaches about 50% in the first year of treatment in first episode psychosis and partial adherence rates range from one- to two-thirds, LAI are widely underused in many settings around the world [7]. Rates of

treatment resistance (TR) are also very high (~30%) and surveys show low rates of clozapine prescription ranging from 2–3% in North America to 15.9% in China and some European countries [8]. Likewise, uptake of psychosocial treatments remains very low even though at least eight different evidence-based psychosocial interventions such as cognitive behavioural therapy, family-based services, and skills training are recommended by experts and people with the disorder [9].

Why are clinicians not able to implement these evidence-based strategies that offer 'realistic hope' to people with schizophrenia? Modern care delivery processes involves an alliance between the clinicians, the person with schizophrenia and their family and carers; this is a move away from paternalistic relationships towards more effective strategies, involving shared decision-making [1]. Doctors have a key role in providing information and support in discussing LAI, clozapine and psychosocial interventions to empower patients and caregivers in their decision-making. However, there can be logistical issues with the (un)availability of both pharmacological and psychosocial interventions, which it is argued, may be more to do with the service resources than with hope, nevertheless, addressing resourcing issues also requires a positive attitude and hope for a positive outcome.

The current negative perspective towards the prognosis of schizophrenia is one example of poor translation of current knowledge to clinical care. Without a positive attitude it is difficult for clinicians to maintain 'hope'; creating a self-fulfilling prophecy, in which a false assessment of the situation evokes a behaviour which makes the original false conception come true [32]. In other words, a biased view of the likely outcome in schizophrenia makes the doctors less hopeful towards the patients' prognosis and thus impacts their prescribing - precluding patients from access to the best treatment options. Inevitably, the lack of the most appropriate treatment impacts on patients, resulting in poorer functioning, and hindering the recovery process. These poor outcomes validate the original hopeless bias, perpetuating the reign of error! In practice, psychiatrists end up citing this course as proof that they were right to be hopeless about the poor prognosis of schizophrenia from the very beginning.

In summary, a hopeful attitude towards schizophrenia is not a naïve optimistic approach and needs to be able to take account of the different stages of the disease. Since 'hope' is not a static trait, bridging the gap between contemporary advances and clinical practice should inject hope into the routine treatment of schizophrenia. As in current educational thinking, a growth mind set [10] advocating 'realistic hope' is *essential* for clinicians to provide a state-of-the-art clinical care for people with schizophrenia.

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UNSTRUCTURED ABSTRACT

According to the experience of people with schizophrenia, their psychiatrists' attitude towards the outcome of their illness is lacking in *hope*, which directly affects the mutual faith in treatment. Here we discuss the scientific basis of *hope* and show its instrumental role on optimizing the best treatment strategies for schizophrenia.

PLAIN ENGLISH SUMMARY

According to the experience of people with schizophrenia, their psychiatrists' attitude towards the outcome of their illness is lacking in *hope*, which directly affects the mutual faith in treatment. Coming from a scientific perspective, we discuss the instrumental role of the clinicians' own *hope* for the implementation of the best treatment options. We show that the enlightening and restitutive power of *hope* is not a naïve hype approach, and should be taken in consideration in order to provide state-of-the-art clinical care for people with schizophrenia.